Supreme Court, U.S.
FILED
NOV 22 1985
JOSEPH F. SPANIOL, JR.
CLERK

No. 85-225

In the Supreme Court of the United States

OCTOBER TERM, 1985

MARGARET M. HECKLER, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL., PETITIONERS

v.

MICHIGAN ACADEMY OF FAMILY PHYSICIANS, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF FOR THE PETITIONERS

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QUESTION PRESENTED

Whether, notwithstanding the preclusions of review in 42 U.S.C. 1395ff and 405(h), the district court properly exercised jurisdiction under 28 U.S.C. 1331 to entertain respondents' challenge to a regulation affecting the carrier's calculation of the amount of benefits payable for certain physicians' services under Part B of the Medicare Program.

PARTIES TO THE PROCEEDING

The petitioners are Margaret M. Heckler, Secretary of Health and Human Services, and Blue Cross and Blue Shield of Michigan, an insurance carrier that has contracted with the Secretary pursuant to 42 U.S.C. 1395u to administer the Part B Medicare Program in Michigan on her behalf.

The respondents are: (1) the Michigan Academy of Family Physicians, a non-profit association of family physicians in Michigan; (2) Lester Webb and Charles Farber, family physicians who are eligible for specialist certification under the standards of the American Board of Family Practice but who have not been certified as specialists under those standards; (3) Glenn House, a family physician certified as a specialist under the standards of the American Board of Family Practice; and (4) Carol A. Diedrich, a resident of Michigan and a Medicare Part B recipient whose treating physician, Philip Lange, is a family physician who is neither Board-certified nor Board-eligible.

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OPINIONS BELOW

The original opinion of the court of appeals (Pet. App. 1a-15a) is reported at 728 F.2d 326. The November 5, 1984 order of the court of appeals (Pet. App. 16a), following the remand by this Court (No. 84-120 (Oct. 1, 1984)), is reported at 751 F.2d 809. The March 19, 1985 opinion of the court of appeals (Pet. App. 17a-22a), rendered on respondents' petition for rehearing, is reported at 757 F.2d 91. The opinion of the district court (Pet. App. 23a-33a) is reported at 502 F. Supp. 751. The earlier memorandum opinion of the district court (J.A. 10-12) denying the Secretary's motion to dismiss the complaint for lack of jurisdiction is unreported.

JURISDICTION

The judgment of the court of appeals was entered on March 19, 1985. The Secretary's petition for rehearing was denied on May 30, 1985 (Pet. App. 35a). The petition for a writ of certiorari was filed on August 9, 1985, and was granted on October 7, 1985 (J.A. 63). The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATUTORY PROVISIONS AND REGULATION INVOLVED

28 U.S.C. 1331; relevant provisions of Sections 205(h), 1842 and 1869 of the Social Security Act, 42 U.S.C. 405(h), 1395u and 1395ff; and 42 C.F.R. 405.504(b) are reproduced at App., *infra*, 1a-6a.

STATEMENT

The question presented in this case is whether the district court had jurisdiction under 28 U.S.C. 1331 to entertain a challenge to a regulation promulgated by the Secretary of Health and Human Services that affects the amount of benefits for certain physicians' services under Part B of the Medicare Program.

A. The Statutory Framework

The Medicare Program is divided into two parts. Part A provides insurance for hospital and related post-hospital services. 42 U.S.C. 1395c, 1395d. Part B establishes a voluntary program of supplementary medical insurance covering, in general, 80% of the "reasonable charge" for physicians' and other medical services. 42 U.S.C. 1395k, 1395*l*, 1395x(s).

1. *Procedural Provisions*

a. Part A of the Medicare Program authorizes the Secretary to enter into contracts with fiscal intermediaries under which the intermediaries deter-

mine whether particular services are covered by Part A and, if so, the amount of benefits that are payable. 42 U.S.C. 1395h. See *Heckler* v. *Ringer*, No. 82-1772 (May 14, 1984), slip op. 2-3. If the intermediary determines that a particular service is not covered by Part A or that the amount of benefits is less than the full cost to the beneficiary, the claimant is entitled to seek reconsideration by the Health Care Financing Administration (HCFA) in the Department of Health and Human Services (HHS). 42 C.F.R. 405.710-405.716. If the intermediary's denial of the claim is affirmed on reconsideration and the amount in controversy is at least $100, the claimant has a statutory right to an evidentiary hearing before an administrative law judge (ALJ) in HHS to the same extent as is provided in 42 U.S.C. 405(b). 42 U.S.C. 1395ff(b)(1)(C) and (2). If the ALJ denies the claim and the Appeals Council sustains that decision, and if the amount in controversy is $1,000 or more, the claimant may seek judicial review to the same extent as is provided in 42 U.S.C. 405(g). 42 U.S.C. 1395ff(b)(1)(C) and (2). See *Ringer*, slip op. 3. On judicial review, the court may consider the validity of any law, regulation or ruling that had the effect of limiting or denying Part A benefits to the claimant. See *Ringer*, slip op. 10-11, 13.

The Medicare Act also provides a mechanism for a hospital or other provider of Part A services to obtain review of the amount it will be reimbursed. A provider is paid an aggregate amount for all Part A services rendered during the relevant time period. See *Heckler* v. *Community Health Services*, No. 83-56 (May 21, 1984), slip op. 2.[1] If the provider is dis-

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[1] The calculation of payments under Part A has been revised by Section 1886 of the Act, 42 U.S.C. (& Supp. I)

satisfied with the intermediary's determination, and if the amount in controversy is $10,000 or more, the provider may request a hearing before the Provider Reimbursement Review Board (PRRB) in HHS. 42 U.S.C. 1395*oo*(a) and (c). The provider then may seek judicial review in district court of an adverse "final decision" of the PRRB. 42 U.S.C. 1395*oo* (f)(1); *Heckler* v. *Community Health Services*, slip op. 6. On judicial review of the PRRB's final decision, the court may consider the validity of any law, regulation, or ruling that had the effect of limiting the amount of reimbursement. In addition, the Act allows a provider to obtain expedited judicial review, without awaiting the PRRB's final decision, of any "question of law or regulations relevant to the matters in controversy whenever the [PRRB] determines * * * that it is without authority to decide the question" (42 U.S.C. 1395*oo*(f)(1); see 42 C.F.R. 405.1842).

b. Congress has provided for far more limited review of benefit determinations under the Part B Medicare Program, at issue here. The Secretary is authorized to enter into contracts with private insurance carriers under which the carriers determine whether particular services are covered by Part B and the amount of the "reasonable charge" for those

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1395ww. That Section institutes a prospective payment system under which providers are reimbursed at a flat rate for each service. See *Heckler* v. *Redbud Hospital Dist.*, No. A-32 (July 24, 1985), slip op. 1-2 (Rehnquist, Circuit Justice). Under the new payment system, the rights of beneficiaries and providers to administrative and judicial review still are governed by 42 U.S.C. 1395ff and 1395*oo*, although Congress has restricted a provider's right of review in several respects. See 42 U.S.C. (Supp. I) 1395ww(d)(7)(B), 1395*oo*(g)(2), discussed at pages 27-28, *infra*.

services. 42 U.S.C. 1395u; 42 C.F.R. 405.803-405.806. See *Schweiker* v. *McClure*, 456 U.S. 188, 190 (1982). If the carrier determines that the services are not covered by Part B or that the payment due is less than the amount claimed, the claimant is entitled to a review determination by the carrier. 42 C.F.R. 405.807-405.811. See *United States* v. *Erika, Inc.*, 456 U.S. 201, 203 (1982); *McClure*, 456 U.S. at 191. If the decision after the review determination is adverse to the claimant and the amount remaining in controversy is $100 or more, the claimant is entitled by statute to an evidentiary hearing by the carrier. 42 U.S.C. 1395u(b)(3)(C); 42 C.F.R. 405.812-405.835. See *McClure*, 456 U.S. at 191.

In contrast to the Part A Program, there is no provision under Part B for administrative review by HHS of the carrier's denial of a claim. 42 C.F.R. 405.502(d). Moreover, although 42 U.S.C. 1395ff (b)(1)(C) expressly provides for the claimant to obtain judicial review of the "amount of benefits" payable under Part A, there is no parallel provision in 42 U.S.C. 1395ff for a claimant to obtain judicial review of the "amount of benefits" payable under Part B. In *Erika*, the Court held that by this omission, Congress "deliberately intended to foreclose further review of such claims" (456 U.S. at 208). Accord *Ringer*, slip op. 5 n.4.

The Act likewise does not contain any special procedures under Part B, similar to those available to Part A providers under 42 U.S.C. 1395*oo*, for a physician to obtain administrative or judicial review of the carrier's determination regarding the amount of benefits payable for covered services. This is because under Part B, benefits are paid to the beneficiary,

not the physician, unless the beneficiary assigns his reimbursement claim to the physician. 42 U.S.C. 1395u(b)(3)(B)(i) and (ii). In the latter event, the physician stands in the shoes of the beneficiary and has the same right to an evidentiary hearing by the carrier. 42 C.F.R. 405.801(a); *Erika*, 456 U.S. at 203, 207 n.7. But as the Court held in *Erika*, Congress also has foreclosed the assignee of a Part B claim from obtaining judicial review.

2. *Substantive Provisions*

a. The Social Security Act requires a carrier that administers the Part B Program to make payment for covered services on the basis of the "reasonable charge" for the services. 42 U.S.C. 1395u(b)(3)(B). In determining the reasonable charge, the carrier must "take[] into consideration the customary charges for similar services generally made by the physician * * * as well as the prevailing charges in the locality for similar services." 42 U.S.C. 1395u(b)(3). Congress amended 42 U.S.C. 1395u(b)(3) in 1972 specifically to provide that "[n]o charge may be determined to be reasonable * * * if it exceeds * * * the prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 percent of the customary charges made for similar services in the same locality during the last preceding calendar year * * *." Pub. L. No. 92-603, § 224(a), 86 Stat. 1395. Applying these principles, the "reasonable charge" for a physician's services ordinarily is the lowest of: (1) the actual charge in the particular instance, (2) the individual physician's customary charge, and (3) the prevailing charge in the locality for similar services (Pet. App. 2a-3a). See 42 C.F.R. 405.502.

b. The regulation respondents challenge in this case was promulgated in August 1967 (32 Fed. Reg. 12601), just one year after the Medicare Program went into effect (see 42 U.S.C. 1395q(a)(1)). It was intended to furnish the carriers guidance in giving content to the "prevailing charge" component of the "reasonable charge" calculation. The regulation recognizes that "[t]he range of prevailing charges in a locality may be different for physicians * * * who engage in a specialty practice or service than for others." 42 C.F.R. 405.504(b). It further permits (but does not require) a carrier, based on "[e]xisting differentials in the level of charges between different kinds of practice or service," to develop "more than one range of prevailing charges for application by the carrier in its determinations of reasonable charges." *Ibid.* The regulation stresses, however, that "[c]arrier decisions in this respect should be responsive to the existing patterns of charges by physicians and other persons who render covered services, and should establish differentials in the levels of charges between different kinds of practice or service only where in accord with such patterns." *Ibid.*

Consistent with this regulation, Blue Cross/Blue Shield of Michigan (BC/BSM), the carrier responsible for administering the Part B Program in Michigan, conducted a statistical analysis of differentials in physicians' charges in that State in 1968. Based on its analysis, BC/BSM identified three categories of physicians for reimbursement purposes: (1) hospital internists and other hospital specialists, (2) other specialists, and (3) general practitioners and other non-specialists. The prevailing charges for specialists in Michigan generally were higher than those

for non-specialists, and a Part B beneficiary therefore ordinarily received a greater dollar amount in reimbursement for the greater expense he incurred in being treated by a specialist. Pet. App. 4a. Following creation of the family practice specialty, BC/BSM in 1973 classified Board-certified family practitioners in the specialist category, but family physicians who were merely eligible for Board certification and family physicians who were neither Board-eligible nor Board-certified were grouped with the non-specialists. *Ibid.*[2]

B. The Proceedings In This Case

1. a. Respondents filed this action on October 8, 1976 in the United States District Court for the Eastern District of Michigan to challenge BC/BSM's classification of family practitioners for purposes of calculating the prevailing charge level for their services (J.A. 1; C.A. App. 11-29). The initial plaintiffs were the Michigan Academy of Family Physicians, one Board-certified family practitioner, and two Board-eligible family practitioners (C.A. App. 11-12, 19, 19-20). Later, a Part B beneficiary who was the patient of a family practitioner who was neither Board-certified nor Board-eligible was joined as a plaintiff (Pet. App. 31a-32a; J.A. 57-59). In their amended complaint (J.A. 14-30), respondents alleged that the differing treatment of family physicians (i) was inconsistent with the requirement in 42 U.S.C. 1395u(b)(3) that the reasonable charge be calculated by reference to the prevailing charge for "similar services," and (ii) violated the prohibition in 42

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[2] The government acknowledged in district court that, under standards in effect at the time of trial, Board-eligible family physicians also should be included in the specialist category (Pet. App. 27a).

U.S.C. 1395a against interference by the Secretary with a beneficiary's selection of a physician (J.A. 26-27). Respondents further alleged that BC/BSM and the Secretary had failed to produce adequate statistical data to support the maintenance of separate charge screens (J.A. 27).[3]

b. On December 28, 1977, the district court denied the motion of the Secretary and BC/BSM to dismiss the complaint for lack of jurisdiction (J.A. 10-12). The district court conceded that in challenging BC/BSM's charge screens, respondents "[w]ithout doubt * * * are motivated in part by a desire for increased payment for services" (J.A. 11). But the court nonetheless held that it had jurisdiction because an invalidation of BC/BSM's charge screens would not necessarily lead to an increase in any particular payments (J.A. 11).

c. On the merits, the district court held in an opinion dated December 30, 1980 that the establishment of separate charge screens is inconsistent with the Medicare Act and that 42 C.F.R. 405.504(b) is invalid to the extent it authorized the screens established by BC/BSM (Pet. App. 23a-33a). The court relied on 42 U.S.C. 1395u(b)(3), which requires the carrier to take into consideration and establish a ceiling based on the prevailing charge level for "similar services" in the locality. In the court's view, the

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[3] Respondents also alleged that the differing treatment of family physicians violated their Fifth Amendment rights to equal protection and substantive due process (J.A. 22-24) and violated their Fifth Amendment right to procedural due process by creating an irrebuttable presumption that their services were worth less than those of other physicians (J.A. 24-26). The district court and court of appeals did not reach these constitutional questions. Pet. App. 5a, 13a n.5, 22a-28a, 32a.

quoted term requires that services performed by physicians with different degrees of specialization be reimbursed at an identical level. Pet. App. 5a, 28a-30a. The court also held that the separate charge screens violate 42 U.S.C. 1395a because they "tend[] to influence the patient's choice of a physician" (Pet. App. 30a-31a). Finally, the court believed that BC/BSM did not identify an adequate factual or statistical basis for distinguishing among groups of physicians (*id.* at 28a, 31a).

2. In an opinion dated February 23, 1984, the court of appeals affirmed the district court's rulings on jurisdiction and the merits (Pet. App. 1a-15a).

a. The court of appeals conceded that 42 U.S.C. 1395ff and this Court's decision in *Erika* foreclose judicial review of the amount of benefits payable for particular services under Part B of the Medicare Program (Pet. App. 6a-8a), because "Congress clearly and convincingly intended that no judicial review of such questions was permissible" (*id.* at 7a). But the court observed that in the wake of *Erika*, several lower courts had "strenuously endeavored to find jurisdiction" over challenges to certain "procedural aspects" of the Medicare Program (Pet. App. 8a), and it elected to do the same. Thus, although the court of appeals acknowledged that "the eventual result of this suit may cause an increase in amounts of reimbursement" for services rendered by family physicians (*ibid.*), it nevertheless held that the suit is not barred by 42 U.S.C. 1395ff and *Erika* because respondents are challenging the "mechanism" for computing the reasonable charge for particular services, not the reasonable charge itself (Pet. App. 8a-9a).

The court of appeals further concluded that the district court's exercise of federal question jurisdiction

under 28 U.S.C. 1331 was not barred by 42 U.S.C. 405(h), which is incorporated into the Medicare Act by 42 U.S.C. 1395ii (Pet. App. 9a-11a). The court acknowledged that in *Weinberger* v. *Salfi*, 422 U.S. 749 (1975), and subsequent decisions, this Court had held that the third sentence of Section 405(h) prohibits a district court from exercising jurisdiction under 28 U.S.C. 1331 over any claim "arising under" the Social Security Act. But it noted that in *Salfi* and the other decisions, this Court had referred to an alternative method for obtaining judicial review pursuant to 42 U.S.C. 405(g). Because there is no provision for review of Part B Medicare claims pursuant to 42 U.S.C. 405(g), the court of appeals held that 42 U.S.C. 405(h) should not be construed to preclude jurisdiction under 28 U.S.C. 1331 over a suit arising under Part B. Pet. App. 10a-11a.

b. On the merits, the court of appeals invalidated 42 C.F.R. 405.504(b) and BC/BSM's methodology for calculating payments for physicians' services by reference to the separate prevailing charge screens (Pet. App. 11a-14a). The court rejected the Secretary's contention that the provision in 42 C.F.R. 405.504(b) for separate charge screens furthers the legislative intent to have reimbursement reflect the actual charge patterns in the community. The court believed instead that the "touchstone of [42 U.S.C. 1395u(b)(3)] is that similar services, once determined, are to be compensated equally, regardless of who performs them" (Pet. App. 12a). The court further explained that because the reimbursement approach BC/BSM followed might create an added incentive for physicians to become specialized and for patients to seek specialized care, "the regulation as applied violates 42 U.S.C. § 1395a, prohibiting in-

fringement of a patient's free choice of a physician" (Pet. App. 14a). The court therefore remanded the case to the Secretary "with instructions to consider similar services in an equal manner regardless of who performs that service" (*id.* at 15a).

3. The Secretary and BC/BSM then filed a petition for a writ of certiorari, arguing that the court of appeals' jurisdictional ruling was contrary to the preclusions of review in 42 U.S.C. 1395ff and 405(h), as interpreted by this Court in *Erika* and the intervening decision in *Ringer*. The Court granted the petition, vacated the judgment of the court of appeals, and remanded the case to the court of appeals for further consideration in light of *Ringer*. *Heckler* v. *Michigan Academy of Family Physicians*, No. 84-120 (Oct. 1, 1984).

4. On remand, the court of appeals at first ordered the case dismissed for lack of jurisdiction, explaining that "the principles stated by the Supreme Court in *Heckler* v. *Ringer* require us to find that the federal courts lack jurisdiction over the present case" (Pet. App. 16a). However, on respondents' petition for rehearing, the panel held that *Ringer* and *Erika* do not preclude the exercise of jurisdiction in this case (Pet. App. 17a-22a).

The court of appeals acknowledged that this Court, in footnote 4 of its opinion in *Ringer*, held that judicial review was barred in that case insofar as it arose under Part B of the Medicare Program (Pet. App. 21a). But although the Court in *Ringer* expressly relied for this proposition on its prior decision in *Erika* (see *Ringer*, slip op. 5 n.4), which in turn relied on the preclusion of review in 42 U.S.C. 1395ff (see 456 U.S. at 206-211), the court of appeals stated that "[i]n reaching its decision in *Heckler* v. *Ringer*[,]

the Supreme Court did not rely on § 1395ff" (Pet. App. 18a n.2). Presumably for this reason, the court of appeals did not discuss 42 U.S.C. 1395ff further.

With regard to the additional preclusion of review in 42 U.S.C. 405(h), the court of appeals acknowledged that this Court held in *Ringer* that the challenge to the ruling there at issue fell within the prohibition in Section 405(h) against the exercise of jurisdiction under 28 U.S.C. 1331 (Pet. App. 19a-20a) and that the application of Section 405(h) does not depend on whether judicial review of the particular claim is otherwise available under the Social Security Act itself (Pet. App. 21a-22a). But without explaining why *Ringer* was not therefore controlling, the court of appeals held that the district court *did* have jurisdiction under 28 U.S.C. 1331 to entertain respondents' challenge to a regulation that affected the amount of benefits payable. The court relied on nothing more than a "presumption" favoring judicial review and its notion that "for every right there must be a remedy" (Pet. App. 22a). The court of appeals further concluded, without elaboration, that *Ringer* does not foreclose judicial review "by a party other than a claimant for benefits" (Pet. App. 21a, 22a).

SUMMARY OF ARGUMENT

I

A. The text and legislative history of the Medicare Act establish that Congress has foreclosed judicial review of matters pertaining to the amount of benefits under Part B of the Medicare Program. The only Section of the Act that provides for any form of review of the amount of benefits under Part B is 42 U.S.C. 1395u(b)(3), which confers a right to a hearing by the carrier on a disputed claim but makes no

provision for administrative review by the Secretary or judicial review by the courts. Moreover, under 42 U.S.C. 1395ff, a beneficiary is expressly granted a right to judicial review concerning his entitlement to participate in the Part A or Part B Medicare Program and to judicial review of the "amount of benefits under Part A." But Section 1395ff conspicuously fails to provide for judicial review of the amount of benefits under Part B. This omission in itself furnishes persuasive evidence that Congress deliberately intended to foreclose such review. As this Court observed in *United States* v. *Erika, Inc.*, 456 U.S. 201, 211 (1982), the legislative history of the original Medicare Act and the 1972 amendments to 42 U.S.C. 1395ff "unambiguously support[s]" this reading of the statutory text. The Court accordingly held in *Erika* that judicial review is entirely foreclosed under Part B, and the Court adhered to that view in *Heckler* v. *Ringer*, No. 82-1772 (May 14, 1984), slip op. 5 n.4.

This case falls squarely within the preclusion of review that Congress twice enacted and this Court recognized in *Erika* and *Ringer*, because the prevailing charge screens respondents challenge operate as a ceiling on the amount of benefits payable for covered services under Part B. Indeed, it is particularly clear that Congress did not intend to permit judicial review of a carrier's determination of the prevailing charge level, because that determination depends on the ascertainment and analysis of legislative facts that are peculiarly within the expertise of the Secretary and the carriers. This conclusion is confirmed by the text of 42 U.S.C. 1395u(b)(3), which requires only that the carrier's methodology for determining the prevailing charge level be "acceptable to the Secretary," and by the recent enact-

ment of an express exception to the judicial review provisions for similar determinations under Part A.

B. The various attempts by the court of appeals and respondents to avoid the preclusion of review under 42 U.S.C. 1395ff and this Court's decisions in *Erika* and *Ringer* are without merit. This case in fact is indistinguishable from *Erika*, because the plaintiff in that case likewise challenged the carrier's methodology for calculating the prevailing charge level for certain Part B services. *Erika* and *Ringer* also make clear that, contrary to respondents' submission, 42 U.S.C. 1395ff does not permit judicial review of so-called "statutory" issues. In each of those cases the plaintiff alleged that the carrier's actions under Part B were inconsistent with the Medicare Act, but the Court nevertheless held that judicial review was barred by Section 1395ff. Nor does it matter that respondents have characterized their suit as a challenge to the Secretary's regulation authorizing the establishment of separate prevailing charge screens, rather than to the amount of benefits paid by reference to the screens themselves. In *Erika* and *Ringer* the plaintiffs challenged the validity of instructions by the Secretary that were binding upon the carrier in the same manner as a regulation, but this Court nevertheless held that judicial review under Part B was precluded.

II

A. The conclusion compelled by 42 U.S.C. 1395ff —that judicial review of a regulation affecting the amount of benefits under Part B is barred because such review is not affirmatively authorized by the Social Security Act—is confirmed by 42 U.S.C. 405(h). The second sentence of Section 405(h) provides that no decision by the Secretary shall be re-

viewed by any "tribunal" except as provided in the Social Security Act itself. The carrier is the Secretary's agent in rendering decisions under Part B. The second sentence of Section 405(h) therefore bars review by a judicial "tribunal" of the carrier's decision regarding the amount of benefits under Part B.

In addition, the third sentence of Section 405(h) specifically precludes the bringing of an action under 28 U.S.C. 1331 to recover on any claim "arising under" the Social Security Act. This Court's decisions in *Ringer* and *Weinberger* v. *Salfi*, 422 U.S. 749 (1975), make clear that this jurisdictional bar is fully applicable where, as here, the plaintiff seeks only declaratory and injunctive relief or characterizes his challenge as "procedural" in nature. *Ringer* also confirms that the third sentence of Section 405(h) is fully applicable where, as under Part B, judicial review is not otherwise made available by the Social Security Act itself.

B. There also is no support for the court of appeals' holding that *Ringer* does not bar judicial review "by a party other than a claimant for benefits" (Pet. App. 22a). One of the plaintiffs in *Ringer* had not submitted a claim for benefits, but the Court nevertheless held that federal question jurisdiction was precluded by Section 405(h). And in *Erika*, the Court foreclosed the supplier of Part B services, not just the beneficiary, from obtaining judicial review. By contrast, under the Part A Program, Congress has expressly afforded providers of services a right of judicial review. See 42 U.S.C. 1395*oo*(f). The fact that Congress did not afford a similar right to their counterparts under Part B is a persuasive indication that Congress deliberately foreclosed such suits by physicians.

III

The court of appeals in the end was forced to fall back on a presumption in favor of judicial review. However, any such presumption under Part B necessarily is overcome by this Court's construction of congressional intent in *Erika* and *Ringer*. Respondents cannot avoid those holdings by relying on a presumption of judicial review where the constitutionality of an Act of Congress is challenged, since they have not attacked the validity of any provisions of the Social Security Act. The Court need not decide whether Congress has foreclosed judicial review of constitutional objections to determinations made in the administration of the Part B Program, because here, as in *Ringer* (slip op. 5 n.4), respondents' constitutional claims are too insubstantial to support subject matter jurisdiction in any event.

ARGUMENT

THE DISTRICT COURT DID NOT HAVE JURISDICTION TO ENTERTAIN RESPONDENTS' CHALLENGE TO A REGULATION AFFECTING THE CARRIER'S DETERMINATION OF THE PREVAILING CHARGE LEVEL FOR PHYSICIANS' SERVICES UNDER PART B OF THE MEDICARE PROGRAM

Respondents invoked the jurisdiction of the district court under 28 U.S.C. 1331 to challenge a regulation that authorizes a carrier to develop separate prevailing charge screens to calculate the amount of Part B Medicare benefits paid for physicians' services. Judicial review of such matters is barred by two separate provisions of the Social Security Act. The first is 42 U.S.C. 1395ff, which provides the exclusive avenue of judicial review for participants in the Medicare Program but does not provide for judicial review of

the amount of benefits under Part B. The second is 42 U.S.C. 405(h), which prohibits the review by any "tribunal" of decisions on claims for benefits under the Social Security Act (except as provided under that Act) and specifically precludes the bringing of an action under 28 U.S.C. 1331 to recover on any claim "arising under" the Social Security Act.

The court of appeals' holding that the district court had jurisdiction notwithstanding these preclusions of review is flatly inconsistent with this Court's decisions in *United States* v. *Erika, Inc.*, 456 U.S. 201 (1982), and *Heckler* v. *Ringer*, No. 82-1772 (May 14, 1984). Those cases, like this one, involved challenges to a rule or instruction of general applicability that bound the carrier and had the effect of limiting the amount of benefits the carrier could pay on individual benefit claims. The Court nevertheless held that judicial review was foreclosed under Part B.

The court of appeals' failure to follow *Erika* and *Ringer* unfortunately is typical of the manner in which some lower courts continue to disregard the clear intent of Congress and the clear pronouncements of this Court on questions of jurisdiction arising under the massive Social Security programs. Congress has carefully specified the circumstances and manner in which judicial review is available under the Social Security Act, in the interest of promoting efficiency and fairness in the administration of the Act and preventing the courts from being flooded with minor disputes that Congress determined were more appropriately left to the Secretary to resolve. This congressional policy is particularly compelling under Part B of the Medicare Program, in which more than 150 million claims are submitted annually. *McClure*, 456 U.S. at 190.

The decision below, if affirmed by this Court, would permit judicial review under Part B whenever a claimant characterizes his challenge to the amount of benefits payable under Part B as a challenge to a regulation of the Secretary or a general policy of the carrier that has a bearing on the disposition of individual claims. Virtually any claimant could cast his challenge in such terms. The result would be to foster the very potential for widespread litigation over minor disputes that threatened to ensue prior to this Court's decision in *Erika*. The Court adhered to its unanimous holding in *Erika* just two Terms ago in *Ringer*, and there is no basis for a different result here.

I. JUDICIAL REVIEW OF THE AMOUNT OF BENEFITS UNDER PART B OF THE MEDICARE PROGRAM IS FORECLOSED BY 42 U.S.C. 1395ff

A. The Text And Legislative History Of The Medicare Act And This Court's Decisions In *Erika* And *Ringer* Bar Judicial Review Of Questions Relating To The Amount Of Benefits Under Part B

1. The Medicare Act provides for only limited review of questions of coverage and the amount of benefits payable under Part B of the Medicare Program. The relevant statutory provisions do not contemplate judicial review.

The carrier with which the Secretary has contracted to administer the Part B Program may make payment for services only on the basis of an itemized bill submitted by the beneficiary or by an assignee of the Medicare reimbursement claim (generally, the physician or other person who furnished the services). 42 U.S.C. 1395u(b)(3)(B)(i) and (ii). The limited review mechanism Congress has provided is trig-

gered by the submission of this "request for payment" (42 U.S.C. 1395u(b)(3)(C)). 42 C.F.R. 405.251, 405.252, 405.803.

If the carrier denies the request for payment and the amount in controversy is $100 or more, the claimant is entitled to "an opportunity for a fair hearing by the carrier." 42 U.S.C. 1395u(b)(3)(C). From the outset of the Medicare Program, the Secretary's regulations implementing this statutory hearing requirement have provided that the carrier hearing officer is bound by implementing regulations, instructions and other guidance issued by HCFA. 42 C.F.R. 405.860. Those regulations also have provided from the outset that the hearing officer's decision is "final and binding upon all parties to the hearing" (42 C.F.R. 405.835; see 42 U.S.C. 405(h)). This "final and binding" effect necessarily applies to the interpretation and application of provisions of the Act, regulations and HCFA instructions on which the decision is based.[4]

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[4] The regulations that require the carrier hearing officer to follow the Secretary's regulations, instructions and policies and declare his decision to be "final and binding" were promulgated in 1967 (43 Fed. Reg. 18028) and remained in effect in 1972. See 20 C.F.R. 405.835, 405.860 (1971). In that year, Congress amended 42 U.S.C. 1395u(b)(3)(C) to add the $100 amount-in-controversy prerequisite for entitlement to a hearing by the carrier (see Pub. L. No. 92-603, § 262, 86 Stat. 1448) and amended 42 U.S.C. 1395ff to reaffirm the preclusion of judicial review under Part B except with respect to an individual's entitlement to enroll in the Part B Program (see Pub. L. No. 92-603, § 299*o*(a), 86 Stat. 1464, discussed at pages 23-24, *infra*). Because Congress in 1972 revisited the Part B Program generally and revised other aspects of the review procedures under Part B—but left in place the regulatory provisions just discussed—the 1972 amendments may

There is no provision in 42 U.S.C. 1395u(b)(3)(C) for review by the Secretary of the carrier's decision on an individual claim. See 42 C.F.R. 405.502(d). There also is no provision in that section for *judicial* review of the carrier's decision or of regulations issued by the Secretary that might have affected that decision. Thus, nothing in 42 U.S.C. 1395u(b)(3)(C)—the only section of the Act specifically dealing with review of claims under Part B—supports a right of judicial review under Part B.

2. The only provisions for judicial review at the behest of a beneficiary under the Medicare Program are contained in a different section of the Act, 42 U.S.C. 1395ff. In Subsection (a) of 42 U.S.C. 1395ff, Congress provided for the Secretary to determine whether an individual is entitled to participate in the Part A and Part B Programs and to determine "the amount of benefits under Part A * * *." A person who is dissatisfied with the Secretary's decision regarding his right to participate in either Part A or Part B is entitled to an administrative hearing pursuant to 42 U.S.C. 405(b) and to judicial review pursuant to 42 U.S.C. 405(g), without regard to the amount in controversy. 42 U.S.C. 1395ff(b)(1)(A) and (B). A person who is dissatisfied with the Secretary's determination regarding the "amount of benefits under Part A" also has a right to administrative and judicial review pursuant to 42 U.S.C. 405(b) and (g), but only if the amount in contro-

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properly be viewed as a congressional ratification of the provisions making the carrier's application of regulations and instructions "final and binding" on the claimant. *Lindahl* v. *OPM*, No. 83-5954 (Mar. 20, 1985), slip op. 12 & n.15; *Merrill Lynch, Pierce, Fenner & Smith* v. *Curran*, 456 U.S. 353, 378-382 (1982).

versy is at least $100 and $1,000, respectively. 42 U.S.C. 1395ff(b)(1)(C) and (2). However, 42 U.S.C. 1395ff conspicuously fails to provide a corresponding right to judicial review of the "amount of benefits" under Part B. As the Court observed in *Erika*, "[i]n the context of the statute's precisely drawn provisions, this omission provides persuasive evidence that Congress deliberately intended to foreclose further review of such claims." 456 U.S. at 208. See also *Block* v. *Community Nutrition Institute*, No. 83-458 (June 4, 1984), slip op. 6.[5]

3. The legislative history "confirms" and "explains [the] logic" of this preclusion of review. *Erika*, 456 U.S. at 208. The Senate Report on the original Medicare Act described the operation of 42 U.S.C. 1395ff as follows (S. Rep. 404, 89th Cong., 1st Sess. 54-55 (1965) (emphasis added)):

> Hearings and judicial review are * * * provided for where an individual is dissatisfied with a determination as to the amount of benefits under

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[5] Congress also has afforded a beneficiary a right to judicial review on questions of coverage in certain limited circumstances under 42 U.S.C. 1320c-4, if the amount in controversy is $2000 or more. That Section applies where a peer review organization, pursuant to contract with the Secretary, has determined that certain medical services are not covered by Medicare because they are or were custodial or not reasonable and necessary, or where services are proposed to be furnished in a hospital when they could be furnished as effectively but more economically on an out-patient basis. 42 U.S.C. 1320c-3(a)(1) and (2). This peer review system has been implemented to date only with respect to services furnished in a hospital or other institution (50 Fed. Reg. 15364 (1985)). Although some Part B services may be affected by the new peer review procedures, there is no right to judicial review under 42 U.S.C. 1320c-4 on the question of the amount of benefits payable for services that are found to be covered.

> the [Part A] hospital insurance plan if the amount in controversy is $1,000 or more. (Under the supplementary plan [Part B], carriers, not the Secretary, would review beneficiary complaints regarding the amount of benefits, and *the bill does not provide for judicial review of a determination concerning the amount of benefits under part B where claims will probably be for substantially smaller amounts than under part A.)* * * * *It is intended that the remedies provided by these review procedures will be exclusive.*

See also H.R. Rep. 213, 89th Cong., 1st Sess. 47 (1965).

Congress reiterated this intent in 1972, when it amended 42 U.S.C. 1395ff to make clear that judicial review is not available on questions of coverage or benefit amounts, unless the claim arises under Part A and the amount in controversy is at least $1,000.[6] Senator Bennett, the sponsor, stated that the amendment was intended to ensure that 42 U.S.C. 1395ff "is not interpreted to mean [that the beneficiary] can take the question of the Federal claim to court" and to confirm "the original intention of the law that the courts can determine only eligibility [to participate in Part A or Part B]" (118 Cong. Rec. 33992

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[6] Some courts had construed the Act as originally passed in 1965 (see 42 U.S.C. (1970 ed.) 1395ff(b)) to permit judicial review of coverage questions under Parts A and B without regard to the amount in controversy. See, *e.g.*, *Ridgely* v. *Secretary of Dep't of Health, Education & Welfare*, 345 F. Supp. 983, 986-988 (D. Md. 1972), aff'd, 475 F.2d 1222 (4th Cir. 1973); *Bohlen* v. *Richardson*, 345 F. Supp. 124 (E.D. Pa. 1972), aff'd, 483 F.2d 918 (3d Cir. 1973); *Cardno* v. *Finch*, 311 F. Supp. 251 (E.D. La. 1970). See also *Erika*, 456 U.S. at 209 & n.12.

(1972)). The Conference Report likewise stated with respect to the 1972 amendment (H.R. Conf. Rep. 92-1605, 92d Cong., 2d Sess. 61 (1972) (emphasis added)):

> The Senate amendment added a new section to the House bill which would make clear that *there is no authorization for an appeal to the Secretary or for judicial review on matters solely involving amounts of benefits under Part B*, and that insofar as Part A amounts are concerned, appeal is authorized only if the amount in controversy is $100 or more and judicial review only if the amount in controversy is $1,000 or more.

As the Court observed in *Erika*, these expressions of legislative intent "unambiguously support" an interpretation of Section 1395ff that bars all judicial review of matters concerning the "amount of benefits" under Part B. The Court adhered to this view in *Ringer* and held that judicial review was entirely foreclosed insofar as that case arose under Part B. *Ringer*, slip op. 5 n.4. See also *Lindahl* v. *OPM*, No. 83-5954 (Mar. 20, 1985), slip op. 21 n.28 (the legislative history discussed in *Erika* confirms "Congress' intent absolutely to preclude review").

4. This case falls squarely within the preclusion of review that Congress intended, because it unquestionably concerns the "amount of benefits under Part B" (H.R. Rep. 213, *supra*, at 47; H.R. Conf. Rep. 92-1605, *supra*, at 61). Respondents challenge the particular prevailing charge screens that BC/BSM has applied to services by certain family physicians. The prevailing charge level establishes a ceiling on the "reasonable charge" for the services of such physicians. 42 U.S.C. 1395u(b)(3). Because the amount of benefits payable under Part B

is 80% of the reasonable charge, respondents' challenge to BC/BSM's prevailing charge ceilings necessarily constitutes a challenge to the amount of benefits payable on individual claims under Part B.

The circumstances of this case also directly implicate the policy considerations that underlie the preclusion of review under Part B. The only illustration the district court offered regarding the effect of the differing charge screens utilized by BS/BSM concerned the prevailing fee limitations in the Lansing area, which is the residence of respondent Diedrich, a Part B beneficiary. The district court observed that the prevailing charge in the case of an initial comprehensive visit was $50 for specialists and $25 for non-specialists, and in the case of a follow-up visit was $12.30 for specialists and $10.70 for non-specialists. Pet. App. 32a. As a result, in many instances the net effect of the separate charge screens was $1.60 per visit. These are precisely the sort of "quite minor" and "trivial" disputes under the Part B program that Congress intended to keep out of the courts. *Erika*, 456 U.S. at 209, 210 n.13, quoting 118 Cong. Rec. 33992 (1972) (remarks of Sen. Bennett).

5. Even if, contrary to this Court's holding in *Erika* and *Ringer*, respondents were correct that Congress has not entirely foreclosed judicial review of all matters bearing on the calculation of the amount of benefits under Part B, it nevertheless is clear that Congress did not intend to permit a Part B beneficiary or his assignee to seek judicial review of the "prevailing charge" aspect of benefit amount determinations.

a. The establishment of the prevailing charge levels for various services in a particular locality de-

pends on the gathering and analysis of legislative facts, including an expert judgment regarding what services are sufficiently similar to be grouped together for these purposes. " '[T]he proper amount of these charges is a matter peculiarly suited to determination by a specialized agency,' " and judicial review of such determinations would "involve the courts in the complex and detailed task of 'ascertaining the appropriate medical charges for technical services—based on facts which vary from community to community' " (*Kechijian* v. *Califano*, 621 F.2d 1, 3 (1st Cir. 1980), quoting *St. Louis University* v. *Blue Cross Hospital Service*, 537 F.2d 283, 289 (8th Cir.), cert. denied, 429 U.S. 977 (1976)). There is no reason to believe that Congress intended to permit an individual beneficiary or his physician to challenge such determinations in court. Cf. *Heckler* v. *Campbell*, 461 U.S. 458, 467-468 (1983).[7]

b. The language of 42 U.S.C. 1395u(b)(3) in fact demonstrates that Congress did not intend that result. As explained above (see page 6, *supra*), Congress amended Section 1395ff in 1972 to impose a ceiling on the "reasonable charge" for particular services. The ceiling is the prevailing charge level that, "on the basis of statistical data and methodology acceptable to the Secretary," would cover 75% of the customary charges made for similar services in the locality during the preceding calendar year.

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[7] It also is essential that the annual prevailing charge screens be established promptly so that they can be applied to the processing of individual claims at the beginning of each fiscal year. Permitting judicial challenges to the prevailing charge screens would substantially undermine the need for expedition and create uncertainty regarding the payment of vast numbers of claims. Cf. *Morris* v. *Gressette*, 432 U.S. 491 (1977).

The very regulation respondents challenge in this suit, 42 C.F.R. 405.504(b), expressly authorizes a carrier to utilize separate charge screens to calculate the prevailing charge level, and that methodology therefore plainly is "acceptable to the Secretary" within the meaning of 42 U.S.C. 1395u(b)(3). The quoted passage makes clear that general oversight by the Secretary was the means Congress chose to assure that carriers properly implement the statutory and regulatory provisions that address the complex calculation of prevailing charge levels. Congress deemed it sufficient that the carrier's statistical data and methodology be "acceptable to the Secretary"; it did not contemplate intervention by the courts.

c. Congress's recent enactment of the prospective payment system under the Part A Medicare Program provides a further indication that Congress did not intend to permit judicial review of the prevailing charge level under Part B. Under the new prospective payment system, Congress directed the Secretary to establish diagnosis related groups (DRGs). Payment for services within each DRG then is to be made at a flat rate, generally without regard to a particular provider's actual cost experience. See 42 U.S.C. (Supp. I) 1395ww(d). Although a provider retains the right to administrative and judicial review under 42 U.S.C. 1395*oo* with respect to the amount it will be reimbursed under Part A if the amount in controversy is $10,000 or more, Congress expressly foreclosed administrative or judicial review under 42 U.S.C. 1395*oo* (or otherwise) of the Secretary's "establishment of diagnosis related groups [and] of the methodology for the classification of discharges within such groups." 42 U.S.C. (Supp. I) 1395ww(d)(7)(B). See also 42 U.S.C.

(Supp. I) 1395*oo*(g)(2). The legislative history explains that Congress precluded review "because of the complexity of such action and the necessity of maintaining a workable payment system" (H.R. Rep. 98-25, 98th Cong., 1st Sess. 143 (1983)). See also S. Rep. 98-23, 98th Cong., 1st Sess. 57 (1983)).

These same considerations weigh heavily against judicial review of prevailing charge screens under Part B. The determination in the Part B Program of what services are "similar" for purposes of grouping them together under the same prevailing charge screen is directly analogous to the establishment of DRGs in the Part A Program and the classification of services within DRGs. The fact that Congress expressly foreclosed judicial review of determinations under Part A that depend on the ascertainment and analysis of legislative facts, even though it otherwise has afforded providers a right to administrative and judicial review under Part A, confirms that Congress did not intend to allow judicial review of prevailing charge level limitations under the Part B Program, in which Congress has completely foreclosed judicial review.

B. The Court Of Appeals' And Respondents' Efforts To Avoid 42 U.S.C. 1395ff And The Holdings In *Erika* And *Ringer* Are Without Merit

In its original opinion finding jurisdiction in this case, the court of appeals candidly conceded that it was following the lead of other courts of appeals that, even "[i]n the wake of *Erika*, * * * ha[d] strenuously endeavored to find jurisdiction over various types of challenges to the procedural aspects of the Medicare part B program despite the language of

[42 U.S.C.] 1395ff" (Pet. App. 8a). The court relied in particular on *Ringer* v. *Schweiker*, 697 F.2d 1291 (9th Cir. 1982), and *Starnes* v. *Schweiker*, 715 F.2d 134 (4th Cir. 1983). See Pet. App. 8a, 9a, 10a, 11a. The court of appeals cited those decisions for the proposition that although 42 U.S.C. 1395ff and *Erika* preclude judicial review of the actual amount of reimbursement in a particular case, they do not bar judicial review of the "mechanism" utilized by the carrier to determine the amount of reimbursement or the actions of the Secretary in the administration of the Part B Program (such as her promulgation of the regulation at issue in this case). See Pet. App. 8a-9a, 10a-11a.

Of course, subsequent to the court of appeals' original opinion, this Court reversed the Ninth Circuit's decision in *Ringer*. It also vacated the Fourth Circuit's decision in *Starnes* and remanded that case for further consideration in light of *Ringer*. See *Heckler* v *Starnes*, No. 83-1149 (June 4, 1984). The Fourth Circuit itself then held in *Starnes* that *Ringer* required dismissal of the case for lack of jurisdiction. *Starnes* v. *Schweiker*, 748 F.2d 217 (1984), cert. denied, No. 84-1309 (Apr. 15, 1985). The precedential support the court of appeals once perceived for its attempt to distinguish *Erika* therefore has been eliminated. See also *Hatcher* v. *Heckler*, 772 F.2d 427, 429-430 (8th Cir. 1985). In any event, as we explain below, *Erika* itself made clear that the preclusion of review in 42 U.S.C. 1395ff applies to challenges to the manner in which the reasonable charge is calculated as well as challenges to the precise amount of benefits in a particular case, and *Ringer* confirms that interpretation.

1. This case is indistinguishable from *Erika* in all material respects. In *Erika*, the plaintiff challenged the carrier's decision to calculate the prevailing charge level on the basis of prices charged at the beginning of the preceding calendar year, without taking into account subsequent price increases. The plaintiff contended that this approach was inconsistent with the statutory requirement in 42 U.S.C. 1395u (b) (3) that the prevailing charge level be calculated on the basis of "customary charges made for similar services in the same locality *during* the last preceding calendar year" (emphasis added). See 456 U.S. at 204-205 & n.2; *Erika, Inc.* v. *United States*, 634 F.2d 580, 588-589 (Ct. Cl. 1980). This Court, however, unanimously held that judicial review was barred. 456 U.S. at 206-211. Like the plaintiff in *Erika*, respondents challenge the carrier's determination of the prevailing charge level. The only difference is that respondents take issue with the carrier's identification of which services are "similar" for purposes of that calculation, while in *Erika* the challenge was to the timing of the calculation. This difference has no bearing on the availability of judicial review. *Erika* therefore squarely controls this case.

2. Respondents next argue (Br. in Opp. 11, 12, 15, 16, 17) that 42 U.S.C. 1395ff should not be construed to preclude judicial review of what they term "statutory" issues that may arise in connection with the carrier's determination and payment of benefits. This assertion also is foreclosed by *Erika* and *Ringer*. As we have just explained, the plaintiff in *Erika* contended that the carrier's formulation of the prevailing charge screen was contrary to the Social Security Act (456 U.S. at 205; 634 F.2d at 588-591), but this Court nevertheless held that judicial review

was foreclosed. Similarly, the plaintiffs in *Ringer* contended that the Secretary's instructions that required the carrier to refuse to pay any amount of benefits for BCBR surgery violated the Social Security Act and the Administrative Procedure Act (see *Ringer*, slip. op. 7 & n.7), but this Court nevertheless held that judicial review was foreclosed under 42 U.S.C. 1395ff and *Erika* insofar as the case concerned the Part B Program (*Ringer*, slip op. 5 n.4).[8]

3. Nor can respondents avoid the foreclosure of review under 42 U.S.C. 1395ff and *Erika* and *Ringer* by characterizing this suit as a challenge to a regulation issued by the Secretary, rather than to the amount of benefits paid by the carrier. This conclusion is evident from the structure of 42 U.S.C. 1395ff. In 42 U.S.C. 1395ff(b), Congress has authorized judicial review of the "amount of benefits under part A." That amount is to be determined "in accordance with regulations prescribed by [the Secretary]." 42 U.S.C. 1395ff(a). On judicial review

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[8] Respondents' submission in this regard also is inconsistent with the legislative history of the 1972 amendments to 42 U.S.C. 1395ff. As we have explained (see note 6, *supra*), some courts had held prior to 1972 that 42 U.S.C. 1395ff did not foreclose judicial review on questions of coverage under Part A or Part B, as distinguished from the amount of benefits payable. One court that had so held in a Part B case sought to justify this result in part on the ground that questions of coverage are more likely to present issues of statutory construction appropriate for judicial resolution. See *Bohlen* v. *Richardson*, 345 F. Supp. at 130; 483 F.2d at 921 & n.13. When Congress amended 42 U.S.C. 1395ff in 1972 to overrule this and other decisions and preclude review on questions of coverage, it necessarily rejected the notion that judicial review is available under Part B with respect to claims for benefits that are couched as issues of statutory construction.

pursuant to 42 U.S.C. 1395ff(b), the beneficiary may challenge the validity of any such regulations that limit the amount of benefits paid on the claim or that guide the fiscal intermediary or the ALJ in computing that amount. See *Ringer*, slip op. 10-11, 13. The corresponding *foreclosure* of judicial review of the "amount of benefits" under Part B likewise must apply to challenges to regulations issued by the Secretary that limit the amount of benefits that a carrier may pay on a particular Part B claim or that guide the carrier in calculating the benefit amount.[9] Indeed, in order even to have standing to bring this suit, respondents must rely on the effect of the challenged regulation on the amount of benefits payable on individual Part B claims. Compare *Ringer*, slip op. 11-12.

Moreover, in *Erika* itself, the plaintiff's claim to increased benefits was based in part on a challenge to instructions issued by the Secretary that bound the carrier in the same manner as formal regulations (see *Ringer*, slip op. 3-4; 42 C.F.R. 405.860) and limited the amount of benefits the carrier could pay. See *Erika, Inc.* v. *United States*, 634 F.2d at 590-591. This Court nevertheless held that judicial review was unavailable.

If there were any doubt remaining on this point after *Erika*, it was dispelled by *Ringer*. That case

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[9] As this Court observed in *Ringer* (slip op. 13), the determination by the Secretary whether to promulgate a generally applicable rule to resolve a particular issue, or instead to permit individual adjudication of that question by the carriers or fiscal intermediaries, is a matter committed to the Secretary's discretion. The availability of judicial review should not depend on whether the Secretary has chosen to issue a regulation on a particular issue or instead to leave the matter to case-by-case adjudication by the carriers.

involved a challenge to a regulation and HCFA instruction that prohibited the payment of *any* benefits for a particular medical service. *Ringer*, slip op. 2-5. Yet the Court held that judicial review was barred by *Erika* insofar as the case concerned the Part B Program. *Ringer*, slip op. 5 n.4. The Court so held even though the plaintiffs in *Ringer*, like respondents herein, did not actually request the Court to award benefits, but instead sought only an invalidation of the regulation and instruction that would bind the carrier in its subsequent adjudication of individual claims for benefits. Slip op. 9-10, 12. Because the Court in *Ringer* explicitly relied on *Erika*, which in turn relied on the foreclosure of review in 42 U.S.C. 1395ff, the court of appeals in this case was simply mistaken when it stated in its most recent opinion that "[i]n reaching its decision in [*Ringer*], the Supreme Court did not rely on § 1395ff" (Pet. App. 18a n.2). And this error might explain the court of appeals' otherwise inexplicable assertion that its jurisdictional holding did not conflict with *Ringer* (*id.* at 22a).

II. THE EXERCISE OF JURISDICTION UNDER 28 U.S.C. 1331 OVER CLAIMS ARISING UNDER THE MEDICARE PROGRAM IS BARRED BY 42 U.S.C. 405(h)

The correctness of the result indicated by 42 U.S.C. 1395ff standing alone—that judicial review of a regulation affecting the amount of benefits under Part B is foreclosed because it is not expressly authorized by the Social Security Act—is confirmed by 42 U.S.C. 405(h).[10]

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[10] By virtue of 42 U.S.C. 1395ii, Section 405(h) is made applicable to the Medicare Program "to the same extent" as it is applicable to Title II of the Act.

A. This Court's Decisions In *Salfi* And *Ringer* Establish That Section 405(h) Bars Federal Question Jurisdiction In This Case

1. The second sentence of Section 405(h) provides that "[n]o findings of fact or decision of the Secretary shall be reviewed by any person, *tribunal*, or governmental agency *except as herein provided*" (emphasis added). This sentence embodies a general rule under the Social Security Act that judicial review of administrative decisions on claims for benefits is unavailable except where expressly authorized by that Act. *Salfi*, 422 U.S. at 759 n.6; *Califano* v. *Sanders*, 430 U.S. 99, 110 (1977) (Stewart, J., concurring). Under the Part B Medicare Program, the carriers render decisions on behalf of the Secretary (see *McClure*, 456 U.S. at 190), and the Secretary is the real party in interest in any litigation (*Erika*, 456 U.S. at 206 n.4, quoting 42 C.F.R. 421.5(b)). The preclusion of review in the second sentence of 42 U.S.C. 405(h) therefore applies to decisions by the carriers under Part B. Because Congress has not affirmatively provided in the Social Security Act itself for review by a judicial "tribunal" of the carrier's decisions under Part B, the second sentence of Section 405(h) precludes such review.

2. The third sentence of Section 405(h) further provides that "[n]o action against the * * * Secretary * * * shall be brought under section[] 1331 * * * of title 28 to recover on any claim arising under this subchapter." The court of appeals' holding that the district court had jurisdiction under 28 U.S.C. 1331 directly contravenes this "sweeping and direct" jurisdictional bar as well (*Salfi*, 422 U.S. at 757).

a. In its original opinion, the court of appeals was of the view that Section 405(h) and *Salfi* did not bar jurisdiction under 28 U.S.C. 1331 because this case "involves not a challenge to an individual amount of reimbursement, but instead a challenge to a regulation by the Secretary establishing the procedure under which reimbursement schedules should be determined" (Pet. App. 10a). This narrow view of the reach of Section 405(h) was demonstrably incorrect even at the time the court of appeals rendered its first opinion.

This Court's construction of the third sentence of Section 405(h) in *Salfi* was not dependent upon the fact that the plaintiffs sought an actual award of benefits. The plaintiffs in *Salfi* also sought a declaratory judgment that the statutory provisions were unconstitutional and injunctive relief prohibiting the Secretary from relying on those provisions to deny benefits in administrative proceedings (App. at 12-13, *Weinberger* v. *Salfi*, *supra*), but the Court did not find jurisdiction under 28 U.S.C. 1331 over those aspects of the case either. 422 U.S. at 764. See *Ringer*, slip op. 12. *Salfi* thus made clear that Section 405(h) does not permit a beneficiary to split off one legal issue bearing on the merits of his claim for benefits and present that issue in an independent action for declaratory or injunctive relief under 28 U.S.C. 1331, so that he then can pursue his reimbursement claim in administrative proceedings armed with the judicial ruling on the discrete legal issue.[11]

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[11] At the time of the court of appeals' first decision, a number of other courts of appeals had read *Salfi* to prevent a claimant from seeking to establish his future entitlement to benefits in a separate action under 28 U.S.C. 1331. See, *e.g.*, *Attorney Registration & Disciplinary Comm'n* v. *Schweiker*, 715 F.2d

Nor had there been any suggestion by this Court that the jurisdictional bar in Section 405(h) was inapplicable to challenges that are "procedural" in nature. To the contrary, the Court made clear in *Mathews* v. *Eldridge*, 424 U.S. 319, 327 (1976), that Section 405(h) barred federal question jurisdiction over the challenge in that case to the procedures used to terminate disability benefits. See *Ringer*, slip op. 11; *Ellis* v. *Blum*, 643 F.2d 68, 77-78 (2d Cir. 1981). See also *Califano* v. *Yamasaki*, 442 U.S. 682, 697-698 (1979).

b. There is no need to consider further the plausibility of the court of appeals' efforts in its first opinion to avoid Section 405(h) and *Salfi*, because this Court's subsequent decision in *Ringer* explicitly rejected the views advanced by the court of appeals in that opinion.

In *Ringer*, the Court held that Section 405(h) barred the bringing of an action under 28 U.S.C. 1331 to challenge instructions and a formal ruling issued by the Secretary. Slip op. 10-12, 16-23. The Ninth Circuit in *Ringer*, like the Sixth Circuit in this case, had held that the plaintiffs' challenge to the instructions and ruling was "procedural" in nature and therefore was not barred by Section 405(h). This Court, however, explicitly "disagree[d] with

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282, 287 (7th Cir. 1983); *V.N.A. of Greater Tift County, Inc.* v. *Heckler*, 711 F.2d 1020, 1024-1027 (11th Cir. 1983), cert. denied, 466 U.S. 936 (1984); *Hadley Memorial Hospital, Inc.* v. *Schweiker*, 689 F.2d 905, 908-910 (10th Cir. 1982); *Humana of South Carolina, Inc.* v. *Califano*, 590 F.2d 1070, 1074-1076, 1079 (D.C. Cir. 1978); *Rhode Island Hospital* v. *Califano*, 585 F.2d 1153, 1158 (1st Cir. 1978); *Dr. John T. MacDonald Foundation, Inc.* v. *Califano*, 571 F.2d 328, 331-332 (5th Cir.) (en banc), cert. denied, 439 U.S. 893 (1978).

the Court of Appeals' separation of the particular claims * * * into 'substantive' and 'procedural' elements" and "disagree[d] in particular with its apparent conclusion that simply because a claim somehow can be construed as 'procedural,' it is cognizable in federal district court by way of federal question jurisdiction." *Ringer*, slip op. 11. The Court held that "to be true to the language of the statute, the inquiry in determining whether § 405(h) bars federal question jurisdiction must be whether the claim 'arises under' the Act, not whether it lends itself to a 'substantive' rather than a 'procedural' label." Slip op. 11. There can be no question in this case that respondents' claim that the Secretary's regulation violates the Social Security Act is a claim "arising under" that Act, irrespective of the "procedural" label respondents attach to their argument.

Ringer likewise rejected the court of appeals' notion that Section 405(h) does not apply where, as here, the plaintiffs do not seek an actual award of benefits or seek review of an administrative decision on a particular claim. The Court explicitly held in *Ringer* that "[i]t is of no importance that respondents here, unlike the claimants in *Weinberger* v. *Salfi*, *supra*, sought only declaratory and injunctive relief and not an actual award of benefits as well." Slip op. 12. Relying on *Salfi*, the Court held that federal question jurisdiction was barred by Section 405(h) because the source for " 'both the standing and the substantive basis for the presentation' of the claims was the Social Security Act" (slip op. 11-12, quoting *Salfi*, 422 U.S. at 760-761). Respondents' claims in this case clearly are barred under this "broad test" of the reach of Section 405(h) (*Ringer*, slip op. 12).

The court of appeals also sought in its first opinion to distinguish *Salfi* and its progeny on the ground that judicial review was in any event available in those cases under 42 U.S.C. 405(g). The court of appeals reasoned that if Section 405(h) were read to bar federal question jurisdiction under the Part B Medicare Program, judicial review would be entirely foreclosed, because 42 U.S.C. 405(g) is not available as an alternative avenue for judicial review under Part B. The court was unwilling to give that effect to Section 405(h). See Pet. App. 10a. Thereafter, however, this Court in *Ringer* explicitly rejected the proposition that the meaning of Section 405(h) somehow shifts depending on whether review is available under Section 405(g). *Ringer*, slip op. 19.

c. Following this Court's remand of the instant case for further consideration in light of *Ringer*, the court of appeals recited most of the controlling aspects of *Ringer* just discussed (Pet. App. 19a-20a). But in a single paragraph and without elaboration, the court of appeals nevertheless reinstated its prior opinion finding jurisdiction under 28 U.S.C. 1331 (Pet. App. 22a). This holding regarding the scope of Section 405(h) obviously cannot stand in light of *Ringer*.

In contrast to the decision below, other courts of appeals have recognized that, in light of *Ringer*, Section 405(h) removes jurisdiction under 28 U.S.C. 1331 in a case such as this. See *Hatcher* v. *Heckler*, 772 F.2d at 430-432; *American Federation of Home Health Agencies, Inc.* v. *Heckler*, 754 F.2d 896, 897-898 (11th Cir. 1984); *Ganem* v. *Heckler*, 746 F.2d 844, 848 (D.C. Cir. 1984); *Smith* v. *North Louisiana Medical Review Ass'n*, 735 F.2d 168, 171-172 (5th Cir. 1984). Indeed, the Sixth Circuit itself recently recognized in a Part A Medicare case that Section

405(h) bars jurisdiction under 28 U.S.C. 1331 over a suit challenging the method by which reimbursement is determined. *Good Samaritan Medical Center* v. *Secretary of Health & Human Services*, No. 84-3923 (Nov. 7, 1985), slip op. 5-7. The court distinguished its holding in the instant case on the ground —explicitly rejected in *Ringer*—that there is an "implied exception" to Section 405(h) where (as under Part B) the Social Security Act itself does not provide for judicial review. Slip op. 7.

B. The Jurisdictional Bar In 42 U.S.C. 405(h) Applies To Suits By Physicians As Well As Suits By Part B Beneficiaries

The court of appeals also held on remand that *Ringer* does not bar a judicial challenge "by a party other than a claimant for benefits" (Pet. App. 22a). Although the court did not explain to whom it was referring in the quoted phrase, it apparently meant anyone who had not yet submitted an actual claim for Part B benefits, or at least any of the respondent physicians who had not done so. This attempt to distinguish *Ringer* is frivolous.

In *Ringer*, one of the Part B beneficiaries had not yet had the BCBR surgery and thus was not in a position to submit a claim for benefits. The Court nevertheless held that 42 U.S.C. 405(h) foreclosed the beneficiary from bringing an action under 28 U.S.C. 1331 to challenge the Secretary's ruling that barred payment for the surgery. Slip op. 16-23. Any respondent in this case who has not submitted a Part B claim is in precisely the same position as that plaintiff in *Ringer*, and his suit under 28 U.S.C. 1331 therefore is equally barred by 42 U.S.C. 405(h).

Moreover, because it is the beneficiaries who pay premiums to be insured under the Part B Program

and who therefore are most directly affected by regulations limiting the amount of benefits, it would be quite anomalous for Congress to permit physicians to obtain judicial review but to deny such review to beneficiaries. The Act itself demonstrates that Congress did no such thing. The carrier may make payment to a physician only if the beneficiary has assigned his claim to the physician. 42 U.S.C. 1395u (b)(3)(B)(ii). The latter's interest in the determination of a Part B claim therefore is entirely derivative of that of the beneficiary. In recognition of this fact, the Secretary by regulation has provided that a physician who accepts an assignment stands in the shoes of the beneficiary and has the same right to administrative review by the carrier. 42 C.F.R. 405.801(a); *Erika*, 456 U.S. at 207 n.7. But the assignee also is subject to the same preclusion of *judicial* review that applies to the beneficiary. The Court so held in *Erika*. There it was the supplier of services, not the beneficiaries themselves, who sought judicial review (456 U.S. at 204), but the Court held that such review was barred.

This foreclosure of review under Part B is confirmed by a comparison with the Part A Program. Congress enacted a separate mechanism by which a hospital or other Part A provider may obtain judicial review of the amount of reimbursement it will receive for services rendered to Medicare beneficiaries. 42 U.S.C. 1395*oo*(f); see pages 3-4, *supra*. "In the context of the statute's precisely drawn provisions," the fact that Congress expressly provided for judicial review for providers under Part A, but not for their counterparts under Part B, furnishes persuasive evidence that Congress "deliberately intended to foreclose" judicial review under Part B in suits brought

by physicians. *Erika*, 456 U.S. at 208. See also *Block* v. *Community Nutrition Institute*, slip op. 6.

III. THE DISTRICT COURT'S EXERCISE OF JURISDICTION IN THIS CASE CANNOT BE SUPPORTED BY A PRESUMPTION IN FAVOR OF JUDICIAL REVIEW

In finding that the district court had jurisdiction in this case, the court of appeals in the end was forced to rely on nothing more than a "presumption" in favor of judicial review, believing that "for every right there must be a remedy" (Pet. App. 20a). But this Court made clear in *Block* v. *Community Nutrition Institute, supra*, that "[t]he presumption favoring judicial review of administrative action is just that—a presumption" (slip op. 8)—and that it may be overcome by a consideration of the language, structure, purpose and legislative history of the statute and the nature of the administrative action involved (slip op. 5, 8-11). When the court of appeals first ruled, this Court already had held in *Erika* that a congressional intent to preclude judicial review under Part B was "persuasive[ly] evidence[d]" by the text of 42 U.S.C. 1395ff and "unambiguously support[ed]" by its legislative history (456 U.S. at 208, 211). Subsequently, the Court, without dissent, adhered to that view in *Ringer* (slip op. 5 n.4). These holdings should have been sufficient for the court of appeals, on remand after *Ringer*, to overcome any presumption in favor of judicial review.

In an effort to establish a jurisdictional toehold, respondents also insist (Br. in Opp. 11-19) that this case presents the question whether Congress has foreclosed judicial consideration of constitutional questions arising in connection with the Medicare Pro-

gram. In their view, there must be a presumption that Congress has not done so, even in the face of the sweeping and cumulative preclusions of review in 42 U.S.C. 1395ff and 405(h). See Br. in Opp. 12-13, 19. From this premise, respondents argue that the court of appeals was correct in finding jurisdiction over *all* aspects of this suit, statutory as well as constitutional. This argument is seriously flawed.

As we have demonstrated in Points I and II, Congress has deliberately and unambiguously foreclosed judicial review of all statutory, procedural, regulatory, and factual issues touching on the amount of benefits payable under the Part B Medicare Program. For this reason, even if respondents were correct that Congress has not also foreclosed challenges that are framed in constitutional terms, such a holding would not permit judicial review of the other issues the courts below reached and decided. Indeed, the district court and court of appeals expressly declined to pass on respondents' constitutional challenge to the differing charge screens. See Pet. App. 5a, 13a n.5, 27a-28a, 32a.

This Court's decision in *Schweiker* v. *McClure*, *supra*, provides no support for respondents' position. In *McClure*, the Court reviewed the merits of a constitutional challenge to the provisions of the Social Security Act that provide for carrier hearing officers, rather than ALJs in the Department of Health and Human Services, to conduct hearings on Part B claims. The Court did not address the question of the district court's jurisdiction to entertain that suit. But even if we assume that the Court in *McClure* believed that 42 U.S.C. 1395ff and 405(h) should not be construed to foreclose a judicial challenge to the constitutionality of a provision of the Social Security

Act itself (cf. *Hatcher* v. *Heckler*, 772 F.2d at 431-432 n.7; compare *Salfi*, 422 U.S. at 762; *Johnson* v. *Robison*, 415 U.S. 361, 366-367 (1974)), that assumption would not assist respondents here. Respondents do not challenge the constitutionality of any provision of the Social Security Act. They challenge only the constitutionality of one carrier's method of calculating the reasonable charge for particular services, in conformity with a regulation issued by the Secretary. *McClure*, *Salfi* and *Johnson* do not indicate that it might be unconstitutional for Congress to foreclose judicial review of constitutional objections to such administrative determinations.

There is no need to resolve that question in this case, however, because here, as in *Ringer* (slip op. 5 n.4), respondents' constitutional contentions are in any event too insubstantial to support subject matter jurisdiction. See *Hagans* v. *Lavine*, 415 U.S. 528, 536-538 (1974). A classification under an Act of Congress providing for the distribution of benefits must be sustained against an equal protection challenge unless the varying treatment of different groups is so unrelated to the achievement of a legitimate governmental purpose as to be irrational or patently arbitrary. See, *e.g.*, *Schweiker* v. *Wilson*, 450 U.S. 221, 230 (1981); *United States Railroad Retirement Board* v. *Fritz*, 449 U.S. 166, 174-177 (1980); *Flemming* v. *Nestor*, 363 U.S. 603, 611 (1960). See also *City of Cleburne* v. *Cleburne Living Center, Inc.*, No. 84-468 (July 1, 1985), slip op. 13; *Vance* v. *Bradley*, 440 U.S. 93, 97 (1979). The Part B Medicare Program was established to "provide medical insurance benefits" (42 U.S.C. 1395j) that are calculated, in general, on the basis of 80% of the "reasonable charge" for covered services (42 U.S.C. 1395*l*(a)(1)).

In determining whether a charge is "reasonable," the carrier is to refer to the prevailing charge for similar services in the community. 42 U.S.C. 1395u(b)(3).

The regulation respondents challenge implements these statutory principles. It is based on the wholly unremarkable proposition that "[t]he range of prevailing charges in the locality may be different for physicians * * * who engage in a specialty practice or service than for others," and it accordingly permits a carrier to develop more than one range of prevailing charges that reflect "[e]xisting differentials in the level of charges between different kinds of practice or service" (42 C.F.R. 405.504(b)). Because the regulation thus provides for differing charge screens based on existing differentials in charging practices, it is, beyond question, rationally related to the legitimate purpose of the Part B Program to provide insurance benefits that are based on the pattern of charges in the community. Respondents' constitutional challenge to the authorization in 42 C.F.R. 405.504(b) for the creation of separate charge screens therefore is wholly insubstantial.[12]

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[12] Respondents also argued in district court that the differing charge screens create an unconstitutional irrebuttable presumption that services rendered by family physicians are worth less than those of other physicians (J.A. 24-26). This contention is frivolous. The Act does not deem the actual "worth" of any individual physician's services to be dispositive of the question of the amount of benefits payable for those services, but then prohibit the claimant from introducing evidence on that question. The system of prevailing charge screens by definition is based on the creation of *categories* of similar services that are not dependent upon the circumstances of any particular claimant. Such a system plainly creates no unconstitutional irrebuttable presumption under this Court's decisions. See *Salfi*, 422 U.S. at 772-774; *United States* v. *Locke*, No. 83-1394 (Apr. 1, 1985), slip op. 18.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

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NOVEMBER 1985

APPENDIX

STATUTORY PROVISIONS AND REGULATIONS INVOLVED

1. 28 U.S.C. 1331 provides:

> The district courts shall have original jurisdiction of all civil actions arising under the Constitution, laws, or treaties of the United States.

2. Section 205(h) of the Social Security Act, 42 U.S.C. 405(h), provides:

> The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under sections 1331 or 1346 of title 28 to recover on any claim arising under this subchapter.

3. Section 1842 of the Social Security Act, as codified at 42 U.S.C. 1395u, provides in pertinent part:

> (a) Authority of Secretary to enter into contracts with carriers
>
> In order to provide for the administration of the benefits under this part with maximum efficiency and convenience for individuals entitled to benefits under this part and for providers of services and other persons furnishing services to such individuals, and with a view to furthering coordination of the administration of the

benefits under part A and under this part, the Secretary is authorized to enter into contracts with carriers, including carriers with which agreements under section 1395h of this title are in effect, which will perform some or all of the following functions (or, to the extent provided in such contracts, will secure performance thereof by other organizations); and, with respect to any of the following functions which involve payments for physicians' services on a reasonable charge basis, the Secretary shall to the extent possible enter into such contracts:

(1)(A) make determinations of the rates and amounts of payments required pursuant to this part to be made to providers of services and other persons on a reasonable cost or reasonable charge basis (as may be applicable);

* * * * *

(b) Applicability of competitive bidding provisions; findings as to financial responsibility, etc., of carrier; contractual duties imposed by contract

* * * * *

(3) Each such contract shall provide that the carrier—

(A) will take such action as may be necessary to assure that, where payment under this part for a service is on a cost basis, the cost is reasonable cost (as determined under section 1395x(v) of this title;

(B) will take such action as may be necessary to assure that, where payment under this part for a service is on a charge basis, such charge will be reasonable and not

higher than the charge applicable, for a comparable service and under comparable circumstances, to the policyholders and subscribers of the carrier, and such payment will (except as otherwise provided in section 1395gg(f) of this title) be made—

(i) on the basis of an itemized bill; or

(ii) on the basis of an assignment under the terms of which (I) the reasonable charge is the full charge for the service and (II) the physician or other person furnishing such service agrees not to charge for such service if payment may not be made therefor by reason of the provisions of paragraph (1) of section 1395y(a) of this title, * * *

* * * * *

(C) will establish and maintain procedures pursuant to which an individual enrolled under this part will be granted an opportunity for a fair hearing by the carrier, in any case where the amount in controversy is $100 or more, when requests for payment under this part with respect to services furnished him are denied or are not acted upon with reasonable promptness or when the amount of such payment is in controversy;

* * * * *

(F) will take such action as may be necessary to assure that where payment under this part for a service rendered is on a charge basis, such payment shall be determined on

the basis of the charge that is determined in accordance with this section on the basis of customary and prevailing charge levels in effect at the time the service was rendered or, in the case of services rendered more than 12 months before the year (ending on June 30) in which the bill is submitted or request for payment is made, on the basis of such levels in effect for the 12-month period preceding such year;

and shall contain such other terms and conditions not inconsistent with this section as the Secretary may find necessary or appropriate. In determining the reasonable charge for services for purposes of this paragraph, there shall be taken into consideration the customary charges for similar services generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for similar services. No charge may be determined to be reasonable in the case of bills submitted or requests for payment made under this part after December 31, 1970, if it exceeds the higher of (i) the prevailing charge recognized by the carrier and found acceptable by the Secretary for similar services in the same locality in administering this part on December 31, 1970, or (ii) the prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 percent of the customary charges made for similar services in the same locality during the last preceding calendar year elapsing prior to the start of the twelve-month period (beginning July 1 of each year) in which the service is rendered. * * *

4. Section 1869 and of the Social Security Act, 42 U.S.C. 1395ff, provides in pertinent part:

(a) Entitlement to and amount of benefits

The determination of whether an individual is entitled to benefits under part A or part B, and the determination of the amount of benefits under part A, shall be made by the Secretary in accordance with regulations prescribed by him.

(b) Appeal by individuals

(1) Any individual dissatisfied with any determination under subsection (a) of this section as to—

(A) whether he meets the conditions of section 426 or section 426a of this title, or

(B) whether he is eligible to enroll and has enrolled pursuant to the provisions of part B of this subchapter, or section 1395i-2 of this title, or section 1819, [footnote omitted] or

(C) the amount of benefits under part A (including a determination where such amount is determined to be zero)

shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

(2) Notwithstanding the provisions of subparagraph (C) of paragraph (1) of this subsection, a hearing shall not be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $100;

nor shall judicial review be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $1,000.

5. 42 C.F.R. 405.504(b) provides:

Variation in range of prevailing charges. The range of prevailing charges in a locality may be different for physicians or other persons who engage in a specialty practice or service than for others. Existing differentials in the level of charges between different kinds of practice or service could, in some localities, lead to the development of more than one range of prevailing charges for application by the carrier in its determinations of reasonable charges. Carrier decisions in this respect should be responsive to the existing patterns of charges by physicians and other persons who render covered services, and should establish differentials in the levels of charges between different kinds of practice or service only where in accord with such patterns.

☆ U. S. GOVERNMENT PRINTING OFFICE: 1985 491507 20055